



KENTUCKY EMPLOYEES' HEALTH PLAN ENROLLMENT APPLICATION FOR

Mail application to:

Perimeter Park West
1260 Louisville Road
Frankfort, KY 40601

THE KENTUCKY RETIREMENT SYSTEMS (KRS)

PY 2010

INSURANCE COORDINATOR SECTION

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Coverage Effective Date

8	0	0	0	0		
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Company Number Sp Gen HD

Reason for Application:

<input type="checkbox"/> < New Retiree	<input type="checkbox"/> < Open Enrollment	<input type="checkbox"/> < QE*	<input type="checkbox"/> < Previously Waived*	<input type="checkbox"/> < Other*
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If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event date _____
Qualifying Event Description _____ Date _____

Additional Information:

<input type="checkbox"/> I am covered under a Medicare Supplemental plan through a state sponsored retirement system	<input type="checkbox"/> I am a retiree returned to work	Is retiree applying for this coverage. <input type="checkbox"/> < Yes <input type="checkbox"/> < No	If "No", what is your relationship to the retiree? <input type="checkbox"/> <input type="checkbox"/>
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SECTION I: DEMOGRAPHIC INFORMATION

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RETIREE SSN (Required)

RETIREE Name (First, MI, Last)

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APPLICANT SSN (If retiree is not applying)

APPLICANT Name (First, MI, Last)

APPLICANT Specific Information

Mailing Address _____

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Date of Birth (MM/DD/YYYY)

City, State, Zip Code _____

County of Residence _____

Country / Mail Code, if not USA _____

Planholder's HOME PHONE NUMBER _____

Planholder's WORK PHONE NUMBER _____

Planholder's Email Address _____

Smoking Status (Required)Have you smoked in the last 2 months? ☐ < Yes ☐ < NoGender ☐ < Male ☐ < FemaleMarital Status ☐ < Single ☐ < Married**SECTION II: PLAN ELECTION-** If waiving (i. decline) health insurance coverage, go to Section V.

1. Option (Check only one) <input type="checkbox"/> < Commonwealth Standard PPO <input type="checkbox"/> < Commonwealth Capitol Choice <input type="checkbox"/> < Commonwealth Optimum PPO	2. Level of Coverage <input type="checkbox"/> < Single <input type="checkbox"/> < Parent Plus <input type="checkbox"/> < Couple <input type="checkbox"/> < Family	3. Cross-Reference Payment Option (Available for Family Coverage Only) <input type="checkbox"/> < Yes If Yes, you must complete Sections III and IV If cross-referenced with an active employee,
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SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → If you elected Single coverage, skip to Section VII

Social Security Number	Name (First, MI, Last)	Gender (Circle one)	Date of Birth (MM/DD/YYYY)	Relationship Code*
		M F		
		M F		
		M F		
		M F		

*Relationship Codes: SP = Spouse, CH = Child, DD = Disabled Dependent, CO = Court-Ordered Dependent

Retiree's SSN

Applicant's SSN (from Page I, Section I)

SECTION IV: CROSS-REFERENCE INFORMATION → Complete ONLY if you checked Yes in Section II, box 3

Your Spouse's Company Number: (Required) _____	Is your spouse a dual employee <input type="checkbox"/> <Yes	Has your spouse smoked in the last 2 months? (Required) <input type="checkbox"/> <Yes <input type="checkbox"/> <No	Is your spouse a Hazardous Duty Retiree? <input type="checkbox"/> <Yes <input type="checkbox"/> <No	Your spouse's Hire Date or Retirement Date: _____
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SECTION V: WAIVER

Do you wish to waive (i.e. decline) your Health Insurance Coverage? By checking "Yes," I understand that I am declining health insurance coverage through the KEHP ☐ < Yes

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA)

Not Applicable → Retirees are not eligible to participate in a Flexible Spending Account.

Cross-referenced with an active employee who wishes to enroll in an FSA? Please complete the enrollment application for active employees instead.

SECTION VII: AUTHORIZATION AND CERTIFICATION

I understand and agree that:

- If my signature on this application creates a legal and binding contract between myself, the Department of Employee Insurance and the TPA.
- **My spouse and I elect the cross-reference payment option, we are dual planholders with Family coverage and that upon a loss of eligibility by either spouse, the remaining planholder will have the option to enroll in either Single or Parent Plus coverage. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder.**
- Each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP Handbook.
- All benefits for myself and eligible dependents be provided in accordance with the plan document.
- I must abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
- The elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
- I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected, including any arrears I may owe.
- **I elect to have the employee contribution for health coverage deducted on a pre-tax basis unless I sign a Post-Tax Form or otherwise acknowledge post-tax treatment for my dependents; for Pre-tax treatment, dependent coverage must meet eligibility requirements of Section 152.**
- I authorize the release of medical claims data to the Kentucky Retirement System for use in data analysis and referral to available health related services upon their review.
- I authorize the Retirement System to release the information in this application to the Social Security Administration. The information in this application may be used by the Social Security Administration to determine Medicare eligibility. I further acknowledge the Medicare eligibility may affect my participation in the Kentucky Employees Health Plan.
- This plan has a tobacco incentive for members who do not use tobacco and that this plan offers tobacco cessation programs.
- I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge. I acknowledge and understand that DEI will comply with the HIPAA rules and that disclosure of information will be done under the rules of such Federal Law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities
- I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for I insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP and it may be used to reduce or deny a claim or to terminate my coverage. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.

Retiree Signature

Date

Applicant Signature (if other than retiree)

Date

Spouse Signature – **REQUIRED** if electing the cross-reference payment option

Date

Retirement Insurance Coordinator Signature

Date

Spouse's Insurance Coordinator Signature – **REQUIRED** if electing the cross-reference payment option

Date